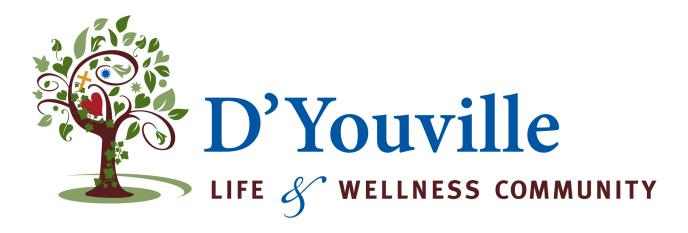
RE:		
DATE REC'D:		
LTC:(for office use only)		
(for office use only)		



D'Youville Senior Care

APPLICATION FOR ADMISSION

APPLICATION FOR ADMISSION

D'Youville Senior Care

Patient Name:	Date:
Address:	Zip: Phone:
Current Location: Home Hospital Other _	Date of Admission:
If Hospital, Case Manager's Name:	
Inquiry made by:	Phone:
DOB: Sex:MF Birthdate:	Religion:
Marital Status: M S W D	Parish/Congregation
Former Occupation:	How did you hear about us?
Are you seeking: Long Term Care	Short Term Care
Contact (1) Name:	Relationship:
Address:	Zip
Home Phone: Email:	Work Phone:
Contact (2) Name:	
Address:	
Home Phone:Email:	Work Phone:
Name of Health Care Proxy Agent:	Power of Attorney
Conservator	Guardian
Method of Payment: Private Medicare	Medicaid Other
Social Security #	Other
Medicare #	Part AYesNo Part BYes No
Other InsuranceYesNo Company:	Policy #:
Phone # Type	of Coverage

Please list patient's medications				
	:			
Patient's Primary Physician:			Pho	ne:
DATIENT OADE INFORMATIO				
PATIENT CARE INFORMATIO				
Does patient feed self? Does patient walk?				Acciet
Walker				
Does patient need assist with th				"
Dressing	_			Transfers
	Bladder			
Describe patient's skin condition				
Any open areas on skin:				
Does patient have any commun	icable diseases? _			
Does patient have any diet restr	ictions or special pr	references? _		
Describe patient's vision and he	aring:			
Describe patient's speech:				
Does patient have any sleep dis	turbance?			
Does patient have any problem	with pain?			
Is patient alert: O	riented to person _		Place	Time
Is patient aware of request for p	lacement:			
Behavior				
Withdrawn No	isy	Cooperativ	re	Anxious
Agitated	Strike out at oth	ners:		Depressed
Does patient have any history of	f emotional/mental o	disorders? _		
Describe patient's daily routine:				

NAME OF APPLICANT SEEKING ADMISSION					
FINANCIAL RESOURCES:					
TOTAL PENSION AMOUNT (PER MONTH)	\$				
SOCIAL SECURITY AMOUNT (PER MONTH)	\$				
OTHER INCOME (PER MONTH)	\$				
REAL ESTATE: DESCRIPTION AND ADDRES LAST 5 YEARS:					
APPROXIMATE VALUE IF CURRENTLY OWN					
MORTGAGE BALANCE:					
NAME OF PERSON(S) ON OWNERSHIP PAP					
IS THERE RENTAL INCOME?					
PLEASE LIST BANK/INVESTMENT/BROKER	AGE ACCOUNTS:				
1 BAL	ANCE \$				
2 BAL	ANCE \$				
3 BAL	ANCE \$				
4 BAL	ANCE \$				
IN THE PAST 60 MONTHS HAS THERE BEEN OF ANY REAL ESTATE, INCLUDING CREAT ESTATE WAS PURCHASED IN ANOTHER PE					
YES NO					
IF YOU PURCHASED A LIFE ESTATE IN ANOTHER PERSON'S HOME, DID YOU LIVE IN THE HOME FOR AT LEAST ONE YEAR AFTER YOU PURCHASED THE LIFE ESTATE? YESNO					

DID YOU, YOUR SPOUSE, OR SOMEONE ON YOU THE DEED OF ANY PROPERTY YOU OWN? YES_	
DID YOU, YOUR SPOUSE, OR SOMEONE ON YOU WAY CHANGE AN ANNUITY? YESNO	
FINANCIALLY RESPONSIBLE PERSON:	
NAME:	
ADDRESS:	
TELEHONE:	EMAIL:
RELATIONSHIP TO APPLICANT	
*PLEASE PROVIDE A COPY OF POWER OF ATTOI AND HEALTH CARE PROXY IF APPLICABLE	RNEY, GUARDIANSHIP APPOINTMENT,
NAME AND ADDRESS OF ATTORNEY HANDLING	AFFAIRS IF APPLICABLE:
PLEASE DISCLOSE ANY ADMISSIONS/CONFINENTACILITIES IN THE PAST 12 MONTHS: FACILITY NAME:	
FACILITY NAME:	DATES:
* PLEASE PROVIDE COPIES OF INSURANCE CAR FINANCIAL RESOURCES LISTED. COMPLETED A OF ATTORNEY, GUARDIANSHIP APPOINTMENT A APPLICABLE. PLEASE SEND TO: D'YOUVILLE SENIOR C. 981 VARNUM AVENUE LOWELL, MA 01854 ATTN: ADMISSIONS 978-569-1000; FAX: 978-349	PPLICATIONS MUST INCLUDE POWER AND/OR HEALTH CARE PROXY IF ARE
SIGNATURE	
DATE	

D'YOUVILLE SENIOR CARE DOES NOT DISCRIMINATE ON THE BASIS OF RACE, COLOR, NATIONAL ORIGINS, HANDICAP OR AGE IN OUR ADMISSION POLICY. THIS IS IN ACCORDANCE WITH LAW AND REGULATIONS: